Before the
WORKERS' COMPENSATION BOARD
State of Oregon

Request Type: ☐ Initial ☐ Supplemental ☐ Amended ☐ Consolidate w/WCB # _____

Requested by: ☐ Atty/Claimant ☐ Claimant ☐ Insurer/Processor ☐ Employer ☐ DCBS

In the Matter of the Compensation of

Name _____
Address _____
_____
Phone # _____

Claimant's Attorney _____
Oregon State Bar # _____
Attorney Firm _____
Address _____
_____
Phone # _____

Request for Hearing and Specification of Issues

Date of Injury _____
Claim # _____
(only one claim number per form)
WCD File # _____

Employer _____
Address _____
_____
Insurer _____
Address _____
_____

Parties must notify WCB of any address changes

A hearing is requested for the reason(s) checked below:

- ☐ **A** DENIAL *(date)* _____
  - ☐ **B** Compensability - complete claim denial
  - ☐ **X** Partial denial after a claim acceptance
  - ☐ **Z** Challenge to notice of acceptance
  - ☐ **V** Worker noncooperation
  - ☐ **K** Aggravation
  - ☐ **L** Responsibility
  - ☐ **C** Medical services (ORS 656.245)
- ☐ **M** NONCOMPLYING EMPLOYER ORDER
- ☐ **O** TEMPORARY DISABILITY
  - ☐ **R** Rate
  - ☐ **D** Period sought _____
- ☐ **F** SUPPLEMENTAL TEMPORARY DISABILITY
  (2nd Employer) Period sought _____
- ☐ **N** ORDER ON RECONSIDERATION **attach copy**
  - ☐ **Y** Classification *(disabling/nondisabling)*
  - ☐ **I** Premature closure
  - ☐ **E** Temporary disability
    Period sought _____
  - ☐ **H** Permanent partial disability
  - ☐ **G** Permanent total disability
- ☐ **Q** OTHER *(Explain and cite ORS)* _____
- ☐ **P** DIRECTOR'S ORDER **attach copy**
- ☐ **S** PENALTY *(Cite ORS)* _____
- ☐ **T** ATTORNEY FEE *(Cite ORS)* _____
- ☐ **W** COSTS

• **INTERPRETER WILL BE NEEDED - Language:** _____	☐ Yes	☐ No
• Amount in controversy is LESS than $1000 (ORS 656.291).	☐ Yes	☐ No
• Compensation stayed *(Carrier appeal of Order on Reconsideration).*	☐ Yes	☐ No
• All day is required for hearing.	☐ Yes	☐ No
• Half day is required for hearing.	☐ Yes	☐ No

NOTICE TO OPPOSING PARTY:

The requesting party demands copies of all medical reports and all other documents pertaining to this claim regardless of whether the responding party intends to rely on them at hearing.

_____ _____
Signature of Requester Date

(Rev 5/2016)